

# CONFIRE ECNS Analysis

January 2026



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## CONFIRE Dispatch Processing of EMS Calls and Disposition of ECNS Eligible Calls January 2026

The following is an analysis of various ECNS call processing components and disposition of callers participating in the ECNS process. The analysis looks at various components in the call processing continuum including determination of ECNS eligibility, proper transfer and capture in the LowCode ECNS processing software, and final disposition of pre-hospital care. Data for this analysis was extracted from CONFIREs CAD database, the LowCode database, and ImageTrend medical records.

Table 1 provides an overview of CONFIREs EMS call volume and EMD effectiveness based on all emergency calls coming into the system. To align with the ECNS data, the numbers are also shown during hours when the ECNS is operational (0700 to 2300 hrs).

*Table 1: EMS 911 calls for service and EMD completion for January 2026*

	All Calls	ECNS Operational Hours Only
<b>Total Emergency EMS Calls</b>	18,407	14,744
<b>Total EMS Calls with Obtainable Determinant Code</b>	14,173	11,400
<b>Total EMS Calls with Determinant Code</b>	12,466	9,874
<b>% of EMD Obtainable EMS Calls with Determinant Code</b>	88.0%	86.6%

Table 2 analyzes these elements using two different approaches. The first approach (column 2) is an ideal, capacity-based analysis using all EMS calls with a determinant code that qualifies for ECNS transfer using International Academies of Emergency Dispatch (IAED) protocols. This also includes eligible calls that occur during times when CONFIRE’s ECNS is not staffed (2301 hrs. to 0659 hrs.).

The second approach (column 3) takes a more refined and real-world operational approach by excluding calls that, while technically eligible by determinant code, are not suitable for ECNS transfer due to situational limitations. Examples of excluded scenarios include

- The patients’ condition becomes more serious during the interrogation.
- The caller is a medical facility.
- The caller is a minor with no adult on scene.
- The Patient is in a public place which inhibits detailed communication with the ECN.
- The patient is completely immobile.
- Other inability to interrogate patient (Language barrier, uncooperative).

Additionally, the second approach considers that CONFIRE’s ECNS center is only staffed from 0700 hrs. to 2300 hrs. and excludes calls that are received outside ECNS operational hours. With these differences, the first approach serves as an indicator of the system’s capacity with ideal circumstances, where the second approach provides a view of the practical application of the program with CONFIRE’s current operations and limitations. These differences are summarized below:

**Summary of Methodological Differences**

<b>Feature</b>	<b>First Approach – Ideal Capacity</b>	<b>Second Approach - Practical Application (CONFIRE Policy)</b>
<b>Time of Call</b>	All hours included	Only calls within ECNS operational hours
<b>IAED Code Eligibility</b>	Included	Included
<b>Situational Limitations (e.g., public setting, minor without adult)</b>	Included	Excluded
<b>Purpose</b>	Measures theoretical capacity	Measures practical effectiveness

Table 2: January 2026 data comparison IEAD Protocol and CONFIRE Adopted Policy.

	Based on IEAD Protocol (All Hours)	Based on CONFIRE Policy (Staffed hours only)
<b>Total Calls Eligible for Low Code:</b>	1,723	1,520
<b>% of EMS calls with Determinant Code Eligible for ECNS</b>	13.8%	12.2%
<b>Total calls eligible for ECNS transfer</b>	1,723	1,310
<b>Total ECNS Eligible Calls Transferred to ECN (Entered in Low Code)</b>	833	833
<b>% of Eligible EMS Calls Transferred to ECNS system</b>	48.3%	63.6%
<b>% of Total EMS Calls Transferred to ECNS</b>	4.5%	4.5%

For the purposes of this report, the remaining charts and graphs will represent the practical application (CONFIRE Policy) methodology.

Table 3: Transport/treatment status of ECNS calls January 2026.

<b>Incoming Calls to Emergency Communications Nurse (ECN) Nurse</b>		
	Total ECNS Transfers	833
	Calls Aborted (Hangups, disconnects, emergency declared)	181
	Total Calls received and completed by ECN	652
<b>Calls Returned for Emergency Transport</b>		
	Triage nurse returned call for Emergency Transport	134
	Number of returned calls for emergencies resulting in actual transport	N/A
	% of returned calls for emergency resulting in transport	N/A
<b>Non-emergency with no Alternative Transport</b>		
	Patient had no alternative means of transport (Transport Unit Sent)	398
	Number of non-emergency ambulance responses that resulted in actual transport.	N/A

	% of non-emergency ambulance responses that resulted in actual transport.	N/A
<b>Total calls to reach ECN that resulted in an ambulance response</b>		532
	% of total calls to reach ECN that resulted in ambulance response	81.6%
	Total ambulance responses that resulted in a transport	N/A
	% of response with transport	N/A
	Number of callers who received ECN directions and did not transport by ambulance.	120
	Number of callers who received ECN directions, but ambulance was sent only because the patient had no other means of transportation.	398
	Potential transport deferrals if alternative transportation was available	518

*Table 4: Recommended Point of Care Disposition for patients completing ECNS process for January 2026\*.*

<b>Disposition of Care Text</b>	<b>Number</b>	<b>Percent</b>
Seek Emergency Care as Soon as Possible	159	54.8%
Seek Face to Face Care within 1-4 Hours	46	15.9%
Emergency Response	66	22.8%
Schedule an Appointment to be Seen by a Doctor/Health Care Professional within the Next 12 Hours (same day)	8	2.8%
Contact Poison Control or Local Pharmacist	1	0.3%
Schedule an Appointment to be Seen by a Doctor/Health Care Professional within the Next 1-3 Days	4	1.4%
Speak to Your Doctor/Health Care Professional to Review the Symptoms As Soon As Possible	3	1.0%
Self-Care	1	0.3%
Schedule a Routine Appointment with a Doctor/Health Care Professional	2	0.7%

*\*This represents recommended care given by the ECN. The ECNS program does not have a mechanism to follow up on whether callers follow through with the recommendations. Also, the numbers in this table includes callers who were provided a recommendation that did not require ambulance transport, but received that transport anyway due to lack of alternative transportation (see table 3 for detail).*

Figure 1: Percentage of ECNS eligible Calls that are transferred to ECN and entered into Low Code system by date.

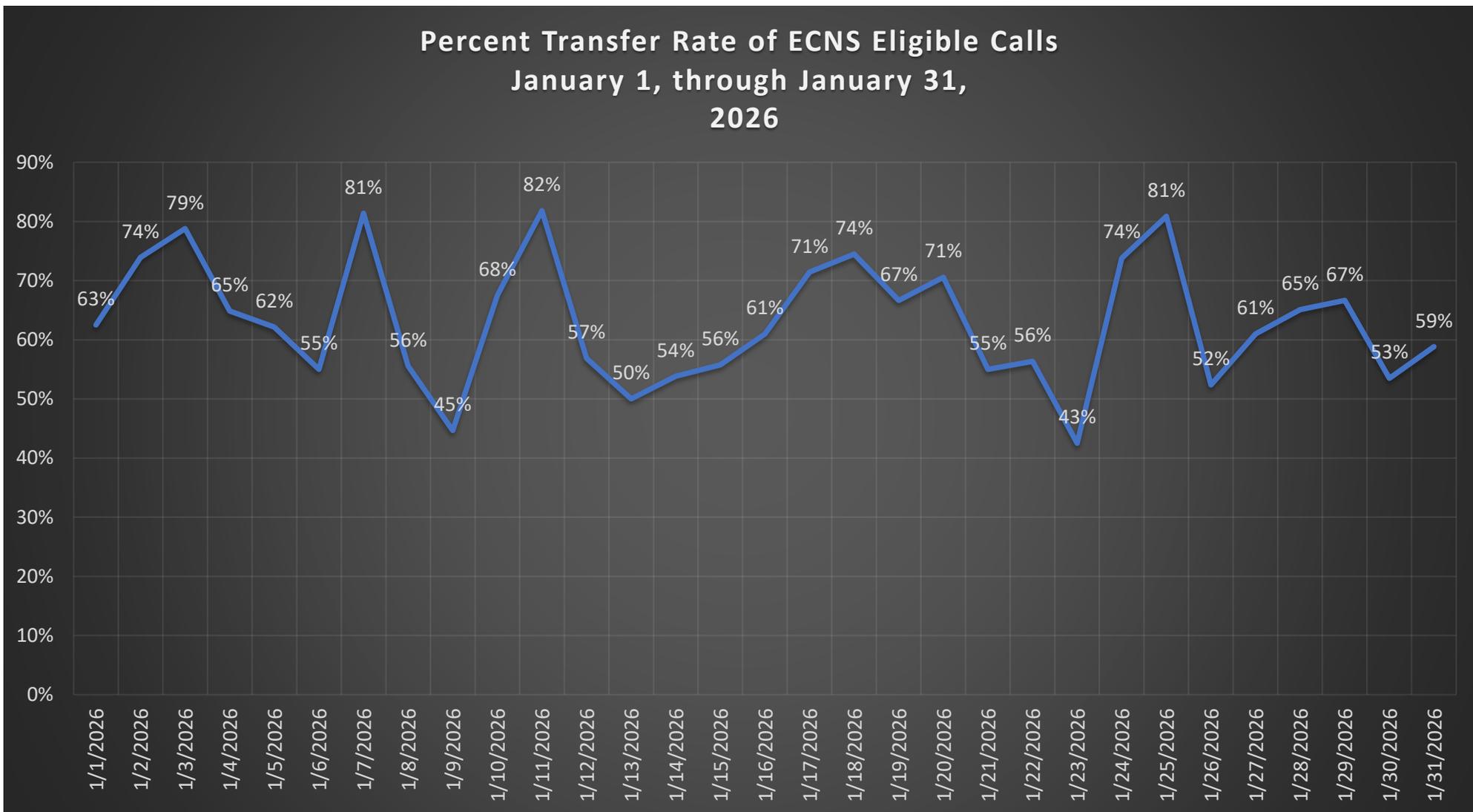


Figure 2: Total number of ECNS eligible calls and the number of them that were transferred to an ECN/entered into Low Code by date.

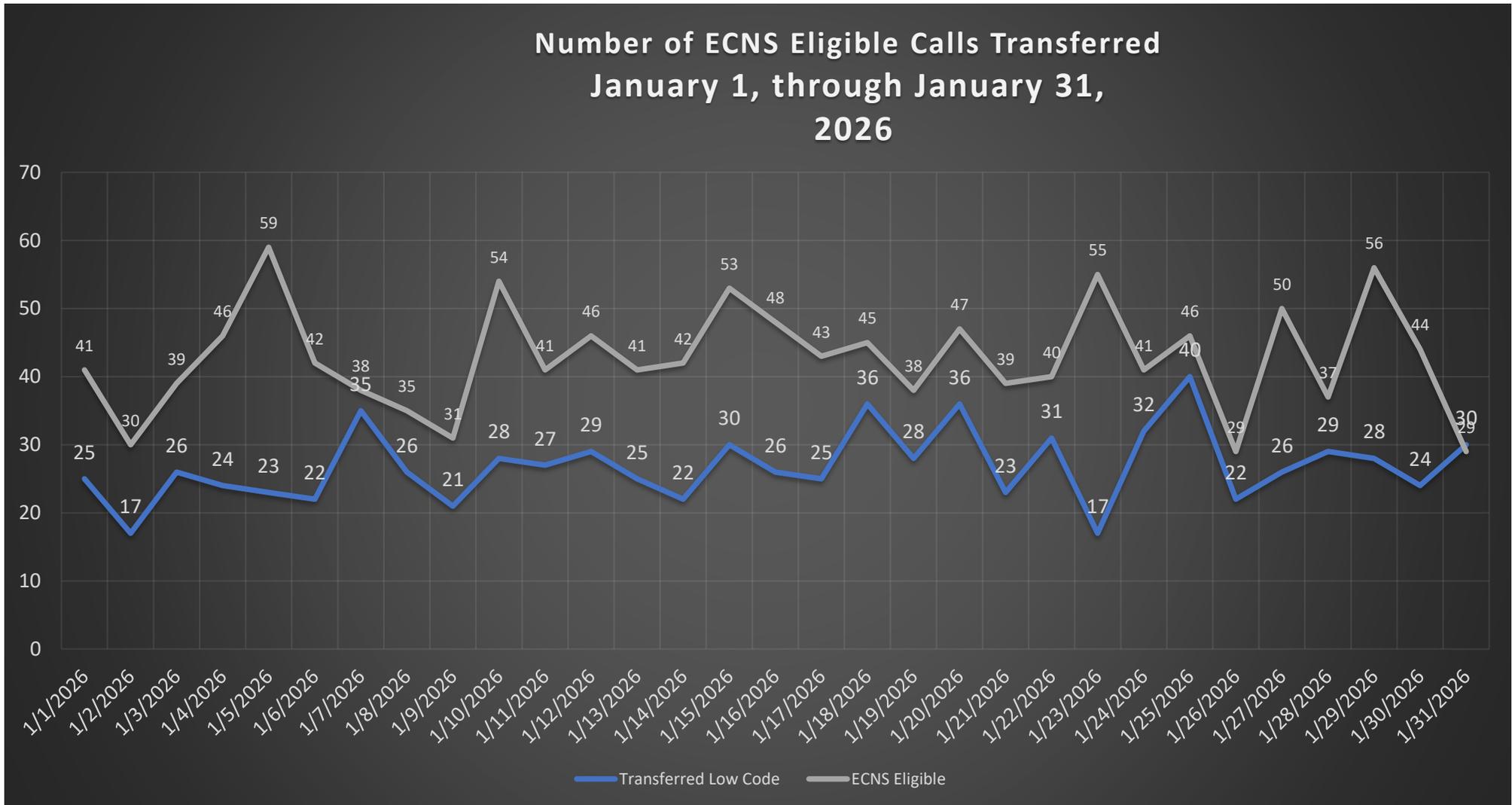
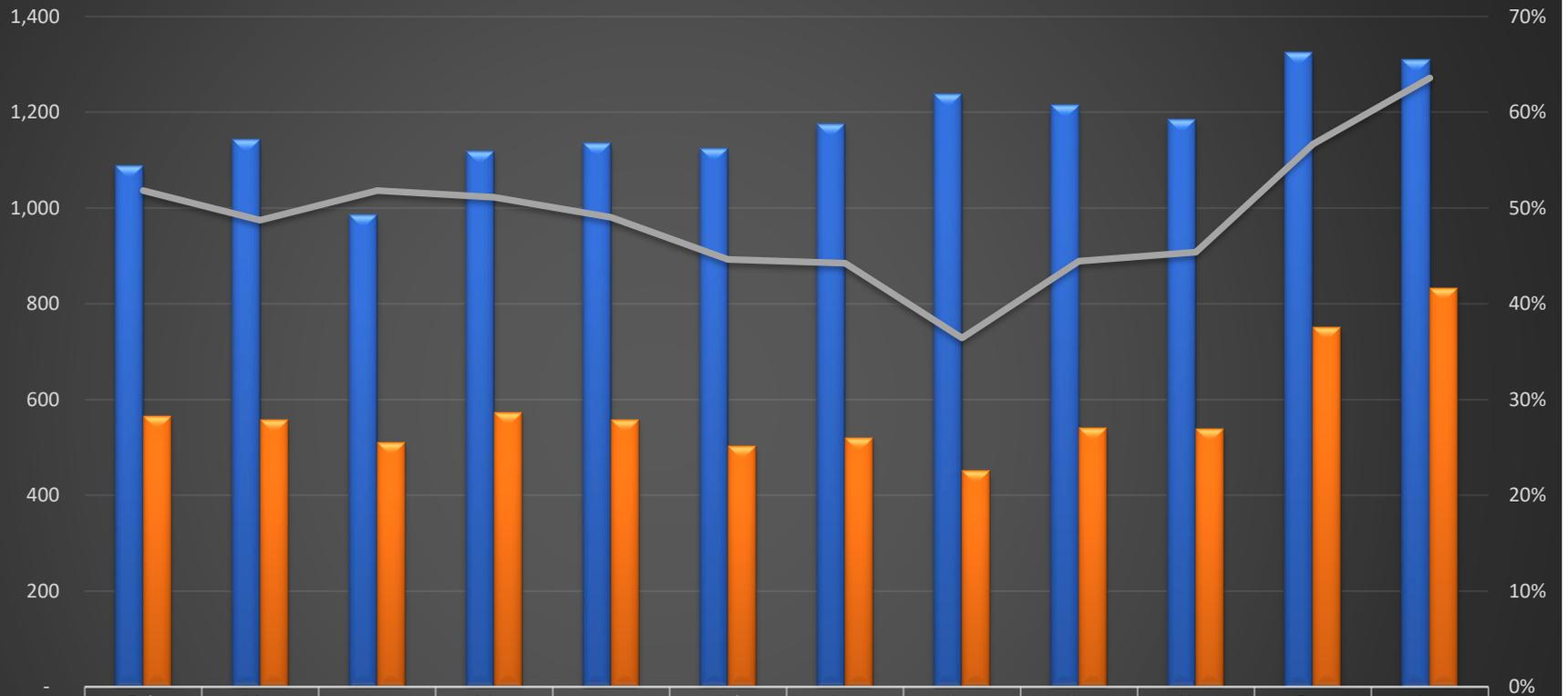


Figure 3: 12-month analysis of ECNS eligible calls and rates of transfer to ECN/Low Code system.

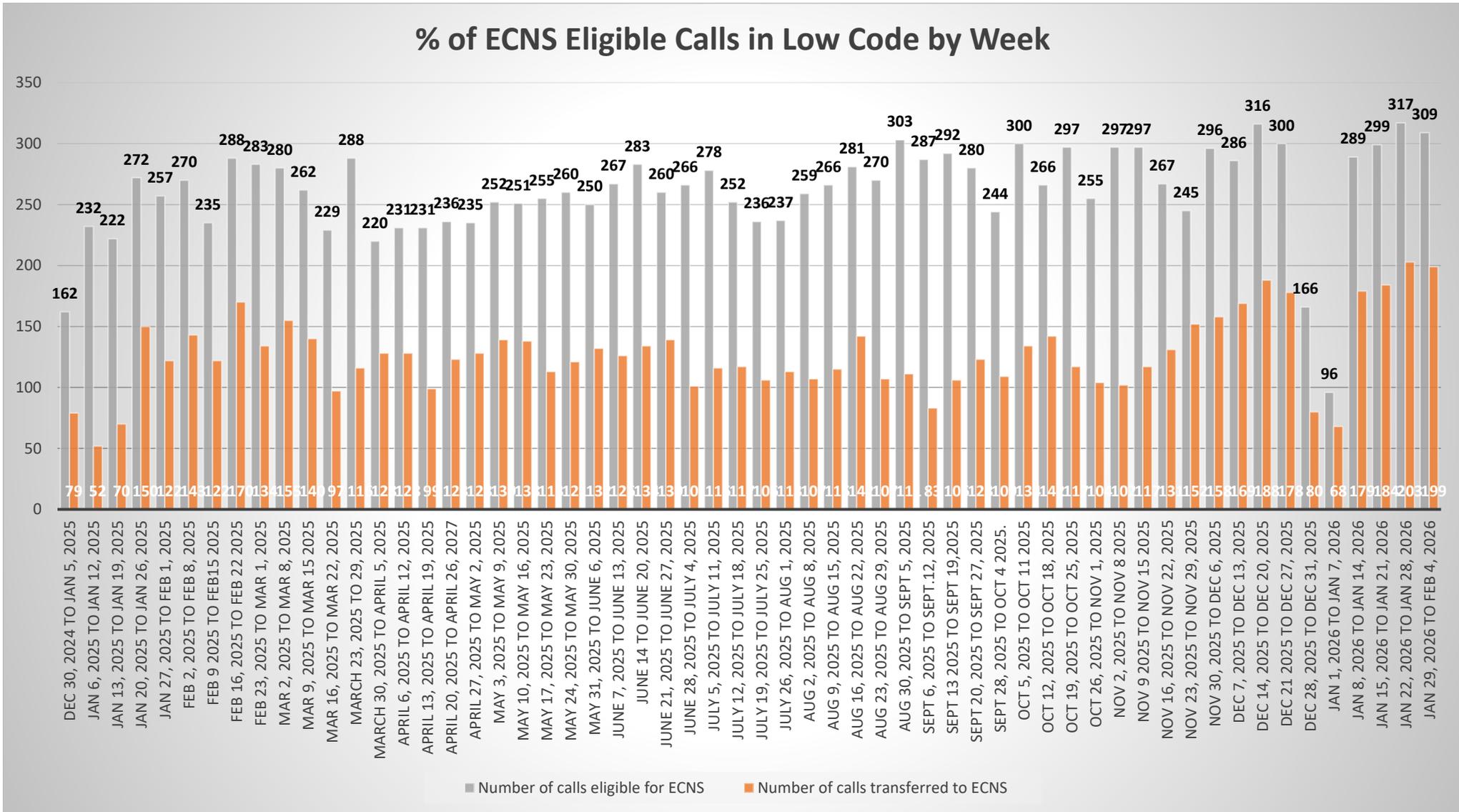
### 12 Month ECNS Transfer Rates Feb 2025 through Jan 2026



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Eligible for ECNS	1,088	1,143	986	1,119	1,136	1,125	1,175	1,238	1,215	1,185	1,325	1,310
Transferred to Nurse Line	564	557	511	572	557	502	520	451	540	538	751	833
% Transferred	52%	49%	52%	51%	49%	45%	44%	36%	44%	45%	57%	64%

■ Eligible for ECNS    
 ■ Transferred to Nurse Line    
 — % Transferred

Figure 4: Number of eligible ECNS calls and rates of transfer from January 2025 through January 2026.



## Reasons why ECNS Eligible Calls were not Transferred to the ECNS Nurse Line

January 2026

CONFIRE’s CAD system is configured to prompt dispatchers whenever a call meets the criteria for potential transfer to the Emergency Communications Nurse System (ECNS). Eligibility is determined by the established determinant code assigned to the incident.

When prompted, the dispatcher may choose to bypass ECNS and dispatch a standard response instead; however, they must select a reason for doing so from a predefined list. The summary below outlines the reasons calls were not transferred.

These determinations rely on the dispatcher’s interpretation of the information available at the time of the call, introducing an element of subjectivity. Additionally, because the list of bypass reasons is predefined, it may not encompass every possible situation. As a result, dispatchers must exercise judgment in selecting the category that best fits the circumstances, even if it does not perfectly describe the situation.

*Table 5: Dispatcher response as to why eligible calls were not transferred to ECNS.*

<b>Disposition Text from CAD</b>	<b>Total Number of Calls</b>	<b>% of Total Eligible Calls Not sent to Low Code</b>	<b>During Staffed Hours Only</b>	<b>% of Total Eligible Calls Not sent to Low Code During Staffed Hours</b>
<b>*Call Taker decided to not send incident to LowCode, with reason: MEDICAL FACILITY RP= RN/Dr requesting 911 AND is at PT bedside</b>	21	1.9%	19	2.7%
<b>*Call Taker decided to not send incident to LowCode, with reason: MINOR AT SCHOOL= PT is a minor at school or NO adult on scene</b>	30	2.7%	30	4.2%
<b>*Call Taker decided to not send incident to LowCode, with reason: REOPENED CALL= Reopened call, call already processed</b>	18	1.6%	18	2.5%
<b>*Call Taker decided to not send incident to LowCode, with reason: FALL= ONLY if PT on ground AND unable to get up</b>	2	0.2%	2	0.3%
<b>*Call Taker decided to not send incident to LowCode, with reason: ECN NOT AVAIL= No ECN staff available in house or remote (Sup Approval Required)</b>	686	62.4%	325	45.8%

<b>*Call Taker decided to not send incident to LowCode, with reason: QUICK LAUNCH= CP, CPR, CVA. SOB, TC, UNC</b>	97	8.8%	86	12.1%
<b>*Call Taker decided to not send incident to LowCode, with reason: 3RD/4TH PARTY=RP is not nor able to be with PT</b>	36	3.3%	34	4.8%
<b>*Call Taker decided to not send incident to LowCode, with reason: REMOTE LOCATION= Coordinates given as location</b>	3	0.3%	3	0.4%
<b>* Call Taker decided to not send incident to LowCode, with reason: 3RD/4TH PARTY=RP is not nor able to be with PT</b>	36	3.3%	34	4.8%
<b>* Call Taker decided to not send incident to LowCode, with reason: MEDICAL FACILITY RP= RN/Dr requesting 911 AND is at PT bedside</b>	21	1.9%	19	2.7%
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